

Title 28. Managed Health Care
Division 1. The Department of Managed Health Care
Chapter 2. Health Care Service Plans
Article 6. Appeals on Cancellations

~~§ 1300.65. Cancellations and Nonrenewals, Request for Review of Cancellations, Rescissions and Nonrenewals.~~

~~(a) Definitions. The terms used in Health and Safety Code sections 1365 and 1389.21, as well as this section and Section 1300.65.1 of this Chapter, are defined as follows:~~

~~(1) Cancelled, Not Renewed or Nonrenewal means termination of coverage initiated by the plan during or at the conclusion of the contract term, but does not include the following:~~

~~(A) Voluntary termination at the request of the enrollee or subscriber.~~

~~(B) Termination for failure to satisfy any statutory or regulatory eligibility requirements under federal or state law.~~

~~(C) Exhaustion of any time-limited coverage provided by federal or state law, including but not limited to continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (Section 4980B of Title 26 of the United States Code, Sections 1161 et seq. of Title 29 of the United States Code, and Section 300bb of Title 42 of the United States Code) or Cal-COBRA (sections 1366.20 through 1366.29 of the Health and Safety Code).~~

~~(D) Prospective termination for failure to satisfy eligibility requirements under a group plan contract, as follows:~~

~~i. Time-based employment requirements, including, but not limited to, a reduction in work hours;~~

~~ii. Marital or registered domestic partner status;~~

~~iii. Attainment of limiting age by dependent child;~~

~~iv. Group participation requirements; or~~

~~v. Service area requirements.~~

~~(E) Termination for enrollees receiving advance premium tax credits ("APTC") pursuant to the Affordable Care Act ("ACA"), section 1401 (26 U.S.C. §36B). Suspension of coverage and federal grace period requirements for fs under the ACA are located in section 1300.65.2.~~

~~(2) Contractholder or contract holder means the individual, group, association or employer with which the plan has contracted to provide health services.~~

(3) ~~Duly Notified and Billed For the Charge~~ means billing information sent to the enrollee, subscriber, or contract holder that, at a minimum, itemizes the premium amount due, the period of time covered by the premium, and the premium due date.

(4) ~~Enrollment or Subscription~~ has the same meaning as “plan contract” as defined in Health and Safety Code section 1345(r).

(5) ~~Grace Period~~ means a period of at least 30 days beginning no earlier than the first day after the last date of paid coverage to allow an enrollee to pay an unpaid premium amount without losing healthcare coverage. At a minimum, this grace period shall extend through the thirtieth (30th) day after the last date of paid coverage. The term “Grace Period” does not include the “Federal Grace Period” as defined in section 1300.65.2, which applies to individuals receiving APTC pursuant to the ACA, section 1401 (26 U.S.C. §36B).

(6) ~~Group contract holder~~ means a group, association, or employer that contracts with a plan to provide health care services to members or employees.

(7) ~~Individual~~ means enrollee or subscriber as defined in Health and Safety Code section 1345(c) and (p), respectively.

(8) ~~Nonpayment of Premiums~~ means failure of the enrollee, subscriber or contract holder to pay any premium, or portion of premium, when due on the date fixed by the plan contract and having been duly notified and billed for the charge to the enrollee, subscriber, or contract holder.

(9) ~~Notice of Consequences for Nonpayment of Premiums~~ means written notice sent by the plan to the enrollee, subscriber, or group contract holder, that the plan contract may be cancelled or not renewed if the premium amount due is not received by the plan.

(10) ~~Notice of Cancellation for Nonpayment of Premiums and Grace Period~~ means notice sent by the plan to the enrollee, subscriber, or group contract holder, that the plan contract will be cancelled, rescinded or not renewed unless the premium amount due is received by the plan no later than the last day of the Grace Period.

(11) ~~Notice of Cancellation, Rescission or Nonrenewal~~ means notice sent by the plan to the enrollee, subscriber, or group contract holder that the plan contract will be cancelled, rescinded or not renewed for any reason other than non-payment of premiums as permitted under this section or section 1300.89.21 of this title, or section 1365 or 1389.21 of the Act.

(12) ~~Rescission or rescind~~ means retroactive cancellation of coverage as defined in section 1300.89.21 of this title.

(13) ~~Request for Review~~ means any written or oral expression of dissatisfaction by an enrollee, subscriber, or contract holder that indicates disagreement with a cancellation, rescission or nonrenewal of coverage.

(14) ~~Small employer~~ has the same meaning as defined in Health and Safety Code sections 1357.500(k) and 1357.600(k).

~~(b) Notice of Consequences for Nonpayment of Premiums~~

~~(1) The plan shall send a Notice of Consequences for Nonpayment of Premiums to the enrollee, subscriber or group contract holder. At a minimum, this Notice shall contain the date the premium is due, and information describing the consequences of the failure to pay the premium amount by the due date. The Notice shall also inform the enrollee, subscriber or group contract holder that the plan shall continue to provide coverage during a 30-day grace period that begins on the first day after the last day of paid coverage.~~

~~(2) For nonpayment of premiums pursuant to Health and Safety Code section 1365(a)(1), the plan shall send the Notice of Consequences for Nonpayment of Premiums:~~

~~(A) Concurrent with the billing information; and,~~

~~(B) Prior to the commencement of the grace period, as defined in this section.~~

~~(c) Notices of Cancellation Requirements~~

~~(1) General Requirements~~

~~(A) The Notice of Cancellation for Nonpayment of Premiums and Grace Period or the Notice of Cancellation, Rescission or Nonrenewal shall be sent by any reasonable method of transmission, including paper, electronic, or another mutually agreeable accessible method of transmission specifically agreed to by the enrollee, subscriber or group contract holder; and,~~

~~(B) For processes other than U.S. Mail, the Plan shall have a tracking system to demonstrate the agreement for the method of transmission between the parties.~~

~~(C) For purposes of this subdivision (c), the enrollee, subscriber or group contract holder may agree to a non-paper form of written transmission of the Notice of Cancellation for Nonpayment of Premiums and Grace Period or the Notice of Cancellation, Rescission or Nonrenewal but shall not be required to opt in to receive a paper transmission of either of these types of notices.~~

~~(2) Notice of Cancellation for Nonpayment of Premiums and Grace Period~~

~~(A) The Notice of Cancellation for Nonpayment of Premiums and Grace Period shall be dated and shall include all of the following:~~

~~(i) Reason for the cancellation;~~

~~(ii) Effective date of the cancellation;~~

~~(iii) The dollar amount due to the plan;~~

~~(iv) The date of the last day of paid coverage;~~

~~(v) The date the grace period begins and expires;~~

~~(vi) The grace period notice requirements provided for in subsection (c)(3)(B);~~

~~(vii) The obligations of the enrollee, subscriber or group contract holder during the grace period (if any);~~

~~(viii) A clear and concise explanation of the right to submit a Request for Review to the Director, including the language provided in subdivision (c)(6) of this regulation; and,~~

~~(ix) Any notice required under Health and Safety Code section 1366.50. This subdivision (c)(2)(A)(ix) shall not apply to a specialized health care service plan contract or a Medicare supplement plan.~~

~~(B) The Notice of Cancellation for Nonpayment of Premiums and Grace Period shall be sent no later than 5 business days after the last day of paid coverage.~~

~~(3) Grace Period Requirements~~

~~(A) General Requirements~~

~~(i) The grace period for cancellation of a plan contract for nonpayment of premiums shall begin no earlier than the first day after the last day of paid coverage. A plan shall not delegate the responsibility for sending the Notice of Cancellation for Nonpayment of Premiums and Grace Period to a group contract holder for each subscriber in the group unless the plan has complied with subdivision (c)(5).~~

~~(ii) The plan must continue to provide coverage pursuant to the terms of the contract for the duration of the grace period.~~

~~(iii) In the event the plan fails to receive the past due amount from the enrollee, subscriber, or group contract holder on or before the last day of the grace period, as specified in the Notice of Cancellation for Nonpayment of Premiums and Grace Period, coverage may be cancelled prospectively only after the end of the grace period.~~

~~(iv) The enrollee, subscriber, or group contract holder is financially responsible for any and all premiums and any copayments, coinsurance or deductible amounts obligated under the plan contract, including those incurred during the grace period.~~

~~(B) Language for the Grace Period Disclosure in the Notice of Cancellation for Nonpayment of Premiums and Grace Period.~~

~~(i) The Notice of Cancellation for Nonpayment of Premiums and Grace Period shall include information describing the duration and effect of the grace period.~~

~~(ii) The Notice of Cancellation for Nonpayment of Premiums and Grace Period satisfies the requirements of subdivision (c)(3) of this section if the notice includes the following language in at least 12 point font:~~

~~"You are receiving this Notice of Cancellation because your [Plan] coverage is being cancelled or not renewed because you have not paid your premium. Even though you have not paid your premiums, you~~

are being provided a "grace period" to allow you time to make your past due premiums payment(s) without losing your health care coverage. "Grace period" means a period of at least 30 days beginning no sooner than the first day after the last day of paid coverage and lasts at least 30 days. Your grace period ends on (insert month, day, year). You may avoid losing your coverage if you pay the premium(s) owed to [Plan] before the end of the grace period. If you do not pay the required premium amount by the end of the grace period, your coverage will be terminated effective the day after the last day of the grace period. Your grace period ends on (insert month, day, year). Coverage will continue during the grace period; however, you are still responsible to pay unpaid premiums and any copayments, coinsurance or deductible amounts required under the plan contract. For information about individual health care coverage and health care subsidies that may be available to you, contact Covered California at (800) 300-1506 or TTY at (888) 889-4500 or online at www.CoveredCa.com. If you wish to end your coverage immediately, please contact [Plan] as soon as possible."

(F) If the enrollee, subscriber or group contract holder, or a party acting on his or her behalf, makes the necessary premium payments to the plan and the payment is received by the Plan on or before the last day of the grace period, the plan shall ensure coverage is not cancelled or not renewed for nonpayment of premium.

~~(4) Notice of Cancellation, Rescission or Nonrenewal~~

~~(A) The Notice of Cancellation, Rescission or Nonrenewal shall be dated and shall include all of the following:~~

~~(i) Reason for the cancellation, rescission or nonrenewal;~~

~~(ii) Effective date of the cancellation, rescission or nonrenewal;~~

~~(iii) A clear and concise explanation of the right to submit a Request for Review to the Director, including the language provided in subdivision (c)(6) of this regulation; and,~~

~~(iv) Any notice required under Health and Safety Code section 1366.50. This subdivision (c)(4)(A)(iv) shall not apply to a specialized health care service plan contract or a Medicare supplement plan.~~

~~(B) The Notice of Cancellation, Rescission or Nonrenewal shall be sent to the enrollee, subscriber or group contract holder no later than:~~

~~(i) At least 30 days prior to the cancellation or nonrenewal for fraud or intentional misrepresentation of material fact pursuant to Health and Safety Code sections 1365(a)(2) or 1389.21, subject to limitations imposed by Health and Safety Code section 1389.21;~~

~~(ii) At least 30 days prior to the cancellation or nonrenewal for a cancellation or nonrenewal pursuant to Health and Safety Code sections 1365(a)(3), (4) or (7);~~

~~(iii) At least 180 days prior to the discontinuation of a contract if the cancellation or nonrenewal is due to the plan ceasing to provide or arrange for the provision of health benefits for new plan contracts in the individual or group market in this state pursuant to Health and Safety Code section 1365(a)(5).~~

~~(C) Pursuant to Health and Safety Code section 1365(a)(5), a Notice of Cancellation or Nonrenewal pursuant to subdivision (c)(4)(B)(iii) of this regulation shall also be sent concurrently to the Director.~~

~~(5) The plan is not required to send a Notice of Consequences for Nonpayment of Premiums to each subscriber in a group contract if the plan sends the Notice of Consequences for Nonpayment of Premiums to the group contract holder. The plan is required to send a Notice of Cancellation for Nonpayment of Premiums and Grace Period or a Notice of Cancellation, Rescission or Nonrenewal to each subscriber in a group contract unless:~~

~~(i) The plan contract requires the group contract holder to promptly send any such Notice to each subscriber; and,~~

~~(ii) The plan sends the Notice to the group contract holder designated in the plan contract.~~

~~(6) Language for Notice of Cancellation for Nonpayment of Premiums and Grace Period or Notice of Cancellation, Rescission or Nonrenewal. The Notice of Cancellation for Nonpayment of Premiums and Grace Period or Notice of Cancellation, Rescission or Nonrenewal satisfies the requirements of subdivision (c)(6) if the notice includes the following language in at least 12 point font:~~

~~"Right to Submit Request for Review of Cancellation, Rescission, or Nonrenewal of Your Plan Contract, Enrollment, or Subscription."~~

~~If you believe your plan coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a Request for Review.~~

~~You have the options of going to the plan and/or the Department if you do not agree with the plan decision to cancel, rescind or not renew your plan coverage.~~

~~Option (1) – You may submit a Request for Review to your plan.~~

~~* You may submit a Request for Review to [Plan] by calling [Plan phone number] or submitting a request at [Plan website], or by mailing your written Request for Review to [Plan address].~~

~~* You may want to submit your Request for Review to [Plan] first if you believe your cancellation, rescission or nonrenewal is the result of a mistake. Requests for Review should be submitted as soon as possible after you receive the Notice of Cancellation, Rescission, or Nonrenewal.~~

~~* The [Plan] will resolve your Request for Review or provide a pending status within three (3) days. If the plan upholds your cancellation, rescission or nonrenewal, it will immediately transmit your Request for Review to the Department of Managed Health Care and you will be notified of the plan's decision and your right to also seek a further review of the plan's decision by the Department as detailed under Option 2, below.~~

~~Option (2) – You may submit a Request for Review to the Department of Managed Health Care.~~

~~* You may submit a Request for Review directly to the Department of Managed Health Care without first~~

Final Text for OAL

~~submitting it to the plan or after you have received the plan's decision on your Request for Review.~~

~~*Requests for Review by the Department of Managed Health Care may be submitted:~~

~~By mail:~~

~~HELP CENTER
DEPARTMENT OF MANAGED HEALTH CARE
980 NINTH STREET, SUITE 500
SACRAMENTO, CALIFORNIA 95814 2725~~

~~BY PHONE:~~

~~1-888-466-2219~~

~~TDD: 1-877-688-9891~~

~~FAX: 1-916-255-5241~~

~~OR ONLINE:~~

~~WWW.HEALTHHELP.CA.GOV"~~

~~(d) Request for Review~~

~~(1) An enrollee, subscriber or group contract holder who believes a plan contract, enrollment or subscription has been or will be improperly canceled, rescinded, or not renewed shall have 180 days from date of the Notice of Cancellation for Nonpayment of Premiums and Grace Period or Notice of Cancellation, Rescission or Nonrenewal to submit a Request for Review to the plan or the Director pursuant to Health and Safety Code section 1365.~~

~~(2) If the enrollee, subscriber, or group contract holder submits a Request for Review to the plan regarding a cancellation, rescission or nonrenewal, the plan shall provide the Department and the enrollee, subscriber or group contract holder with a disposition or pending status on the Request for Review within 3 calendar days of receipt by the plan pursuant to Health and Safety Code section 1368 and section 1300.68.01 of this title. If the plan upholds the cancellation, rescission or nonrenewal, the plan shall immediately transmit the Request for Review to the Director.~~

~~(3) Upon receipt of a Request for Review, the Director shall determine whether the request is timely and shall notify the plan and the enrollee, subscriber, or group contract holder who submitted the request that it has been accepted.~~

~~(4) Within five (5) calendar days of the Director's notice of acceptance of a Request for Review, the plan shall provide the Director with a copy of all information the plan used to make its determination and all other relevant information necessary for the Director's review.~~

~~(5) If an enrollee, subscriber, or group contract holder submits a Request for Review prior to cancellation, rescission, or nonrenewal, the plan shall continue to provide coverage as specified in subdivision (e) of this section.~~

~~(6) Within 30 calendar days of the receipt of Request for Review, or longer if the Director determines in his or her discretion that additional time is necessary to review the cancellation, rescission or nonrenewal, the Director shall send written notice of the final determination and reasons therefore to the enrollee, subscriber, or group contract holder, and to the plan.~~

~~(7) If the Director determines the cancellation, rescission, or nonrenewal is contrary to existing law, the Director shall order reinstatement, in accordance with subdivision (f) of this section, or direct the plan not to cancel coverage.~~

~~(8) If the Director finds the cancellation, rescission, or nonrenewal was proper, but the effective date was inconsistent with the requirements of this section, the Director may exercise his or her discretion and adjust the effective date of the cancellation, rescission, or nonrenewal accordingly and notify the enrollee, subscriber, or group contract holder, as well as the plan of the adjusted cancellation date.~~

~~(9) The plan may request a hearing within 15 days of the Director's final determination.~~

~~(e) Continuation of Coverage~~

~~(1) If the enrollee, subscriber, or contract holder files a Request for Review prior to the effective date of a cancellation, rescission, or nonrenewal, for reasons other than cancellation or nonrenewal due to nonpayment of premiums, the plan must continue to provide coverage to the enrollee, subscriber or contract holder pursuant to the terms of the plan contract while the Request for Review is pending with the plan and/or Director.~~

~~(2) During the period of continued coverage, the subscriber and/or contract holder, remains responsible for paying premiums and any copayments, coinsurance or deductible obligations as required under the plan contract.~~

~~(3) If the Director determines the cancellation, rescission or nonrenewal is consistent with existing law, the plan may terminate the plan contract no earlier than the end of the paid coverage period or notice period described in subdivision (c)(2)(A)(ii) or (c)(2)(A)(iv) of this section, whichever is longer. The enrollee, subscriber or contract holder shall be responsible only for the required premium and cost sharing obligations incurred during the continued coverage period.~~

~~(f) Reinstatement of Coverage~~

~~(1) If the Director determines the cancellation, rescission or nonrenewal, including a cancellation for nonpayment of premium, does not comply with existing law, and the enrollee, subscriber, or contract holder submitted the Request for Review after the plan contract was cancelled, rescinded, or not renewed, the Director shall order the plan to reinstate the enrollee, subscriber, or contract holder, retroactive to the day of cancellation, rescission, or nonrenewal.~~

~~(2) Within 15 days after receipt of the order for reinstatement, the plan may request a hearing from the Director or reinstate the enrollee, subscriber, or contract holder.~~

~~(3) If the Director orders reinstatement, the plan shall be liable for the expenses incurred by the enrollee, subscriber, or contract holder for covered health care services, less any applicable deductibles,~~

~~copayments, or coinsurance, from the date of cancellation, rescission, or nonrenewal through the date of reinstatement. The plan shall reimburse the enrollee, subscriber, or contract holder for any expenses incurred pursuant to this paragraph within 30 days of receipt of the complete claim.~~

~~(4) The subscriber or contract holder shall be responsible for any and all premium payments accrued from the date of cancellation.~~

~~(g) Applicability~~

~~This section shall not apply to an individual who has coverage through the Medi-Cal Program pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code.~~

~~(h) Review and Enforcement~~

~~The failure of a plan to comply with the requirements of section 1365 of the Act and this regulation may constitute a basis for disciplinary action against the plan. The Director shall have the civil, criminal, and administrative remedies available under the Act, including Health and Safety Code section 1394.~~

~~NOTE: AUTHORITY CITED: SECTION 1344, HEALTH AND SAFETY CODE. REFERENCE: SECTIONS 1365 AND 1389.21, HEALTH AND SAFETY CODE.~~

~~§ 1300.65.1. Form to Request for Review of Cancellation, Rescission or Nonrenewal of Plan Contract.~~

~~(a) A Request for Review of the cancellation, rescission, or nonrenewal, of a plan contract, enrollment or subscription pursuant to Health and Safety Code section 1365(b) may be made electronically, verbally or in writing signed by the subscriber, enrollee (or the legal representative of the subscriber or enrollee) or group contract holder.~~

~~(b) An enrollee, subscriber, or group contract holder is not required to use the form below to initiate a Request for Review.~~

~~(c) The plan shall make the following Request for Review form readily available to its members:~~

**STATE OF CALIFORNIA
Department of Managed Health Care**

To: Department of
Managed Health
Care

Date:

Today's Date — Month Day, Year

Help Center
980 9th Street, Suite 500
Sacramento, CA 95814
Fax: (916) 229-0465
www.healthhelp.ca.gov

RE: REQUEST FOR REVIEW OF CANCELLATION, RECISSION, OR NONRENEWAL OF HEALTH CARE SERVICE PLAN BENEFITS

I request that the Director of the Department of Managed Health Care review the cancellation, rescission, nonrenewal of the plan contract, enrollment, or subscription for health plan benefits pursuant to sections 1365 or 1389.21 of the Knox Keene Health Care Service Plan Act of 1975, as follows:

1. Name of enrollee, subscriber, or group contract holder whose benefits were cancelled, rescinded, or not renewed:

Full Name — First Middle and Last Names

2. Name of subscriber, if different than "1" above:

Full Name — First Middle and Last Names

3. Name of plan:

4. Subscriber or Enrollee Account or Identification Number:

5. If applicable, the Group Identification Number:

6. Date notice of cancellation was received (if known):

Date of
Notice: _____

Month Day, Year

7. Attach copies of:

(a) The notice of cancellation sent by the plan.

(b) Any correspondence with the plan regarding the cancellation, rescission, or renewal.

(c) Proof of payment for the last paid coverage period and date of payment.

8.

Do you know why the plan cancelled, rescinded, or did not renew your coverage? If yes, please explain.

Yes No

9. State why you believe the cancellation, rescission, or nonrenewal is wrong.

10. Explain why you believe that the cause or causes for cancellation described in the notice of cancellation are wrong. Attach copies of any documents that help explain your position.

11. Does the cancellation, rescission, or nonrenewal prevent you or any enrollee covered under the policy from receiving medically necessary health care services? If "yes," please explain:

Yes No

12. Has the person named in item "11" above, whose health care benefits were cancelled, rescinded, or not renewed, received any medical or health care since the cancellation, rescission, or nonrenewal? If "yes," what services were received and how much did they cost?

Yes No

Signature of Complainant:

NOTE: AUTHORITY CITED: SECTION 1344, HEALTH AND SAFETY CODE. REFERENCE: SECTION 1365, HEALTH AND SAFETY CODE.

§ 1300.65.2.—Suspension of Coverage Under Federal Grace Period for Nonpayment of Premiums, Notice Requirements.

(a) Definitions and Applicability:

(1) APTC Enrollee means an individual, an enrollee or a subscriber in the individual market who is currently a recipient of advance payments of the premium tax credit ("APTC") pursuant to the Affordable Care Act ("ACA") section 1401 (26 U.S.C. § 36B).

(2) Federal Grace Period means the period of three consecutive months a Qualified Health Plan issuer must provide to an APTC enrollee pursuant to title 45, Code of Federal Regulations ("CFR"), part 156.270, prior to terminating the APTC enrollee's coverage for nonpayment of premium, as defined in 45 CFR part 155.430. To qualify for the federal grace period, the APTC enrollee shall have paid at least one full month's premium during the benefit year.

(3) Qualified Health Plan or QHP Issuer or plan means, for the purposes of this section, a plan licensed under the provisions of the Act and certified by the California Health Benefits Exchange ("Exchange" or "Covered California") to market individual and/or small group products on the Exchange. Any of the requirements contained in this regulation that are delegated by a QHP to a delegated group shall also apply to that delegated group.

(4) Suspension of Coverage means the withholding of coverage by a QHP issuer for health care services

~~provided to an APTC enrollee during months two and three of the federal grace period.~~

~~(b) Suspension of Coverage~~

~~(1) During the first month of the federal grace period, the QHP issuer shall~~

~~(A) Pay all claims covered under the APTC enrollee's Evidence of Coverage for health care services provided to the APTC enrollee; and~~

~~(B) If the APTC enrollee does not pay outstanding premiums by day 15 of the first month of the federal grace period, provide a Notice of Suspension of Coverage to the enrollee pursuant to subdivision (c) below.~~

~~(2) During months two and three of the federal grace period, the QHP issuer shall do the following:~~

~~(A) Suspend coverage for the APTC enrollee pursuant to subdivision (c) below;~~

~~(B) Notify the APTC enrollee's providers pursuant to subsection (d) of the APTC enrollee's Suspension of Coverage no later than day 15 of the second month of the federal grace period;~~

~~(C) Make any necessary system adjustments by day 1 of the second month of the federal grace period to the health plan's real time eligibility and verification system to accommodate the APTC enrollee's Suspension of Coverage. For the purposes of this subdivision (b)(2)(C), the QHP shall only use the terms "coverage pending," "coverage suspended," or "inactive pending investigation" so as to clearly communicate the status of the APTC enrollee; and~~

~~(D) Reinstate the APTC enrollee if the APTC enrollee pays all outstanding premiums prior to the end of the federal grace period, pursuant to subdivision (e) below.~~

~~(3) During the Suspension of Coverage, the APTC enrollee:~~

~~(A) May submit a Request for Review pursuant to Health and Safety Code section 1365(b) and Section 1300.65;~~

~~(B) May purchase health care services from the APTC enrollee's providers or out of network providers by paying for the out of pocket costs, including co-payments, co-insurance and deductibles, for the services on a fee for service basis; and~~

~~(C) Remains responsible for making all delinquent and ongoing premium payments.~~

~~(4) The QHP issuer shall comply with any and all federal notifications requirements related to the federal grace period and coverage terminations due to nonpayment of premiums.~~

~~(c) Enrollee Notice Requirements~~

~~Notice to an APTC enrollee regarding the federal grace period and Suspension of Coverage shall comply with federal requirements and shall include all of the following:~~

- (1) A description of the purpose of the Notice;
- (2) The dollar amount due;
- (3) Date of the last day of paid coverage;
- (4) A notice unique identification number;
- (5) The name and contact information for the subscriber;
- (6) Names of all enrollees affected by the Notice;
- (7) The name of the QHP issuer;
- (8) An explanation of the three-month federal grace period and the date the grace period expires;
- (9) The telephone number for the QHP customer service;
- (10) Consequence of losing coverage, including, financial responsibility for the payment of claims incurred and the obligations of the subscriber.

(d) Provider Notice Requirements

- (1) Notice to providers shall comply with all federal requirements and shall include all of the following:

- (A) A description of the purpose of the Notice;
 - (B) A notice unique identification number;
 - (C) The name of the APTC enrollees affected by the Notice;
 - (D) The name of the QHP issuer for the APTC enrollee;
 - (E) An explanation of the federal grace period including whether the APTC enrollee is in the second or third month of the federal grace period and the provider's rights during this time;
 - (F) The QHP issuer customer service telephone number for providers.
- (2) Notice shall be given to the APTC enrollee's assigned group, assigned network provider, any provider with an outstanding prior authorization to provide services to the APTC enrollee, and to any network provider that submitted claims for the APTC enrollee in the two months prior to the APTC enrollee's federal grace period.

- (3) This Notice requirement is in addition to the provider's ability to verify APTC enrollee eligibility for coverage with the QHP.

- (4) The provider notice requirements contained in this subdivision (d) do not replace a provider's

~~responsibility to verify eligibility for coverage of an APTC enrollee with the QHP issuer before providing health care services.~~

~~(5) In the event the QHP issuer does not provide the notice required in this subdivision (d) to providers or update its real time eligibility and verification system by day 1 of the second month of the grace period, and providers provide health care services to the APTC enrollee, the QHP issuer shall be responsible for paying the cost of the claim of any APTC enrollee that would have been covered under the plan contract notwithstanding the Suspension of Coverage.~~

~~(e) Reinstatement of Coverage~~

~~(1) Upon payment of all outstanding premiums prior to the expiration of the federal grace period, the plan shall reinstate the APTC enrollee's coverage pursuant to the plan contract and immediately update its real time eligibility and verification system to reflect an "active" status.~~

~~(2) If the APTC enrollee pays all outstanding premiums prior to end of the federal grace period, the QHP issuer shall be liable for the claims covered under the APTC's Evidence of Coverage less any applicable deductibles, copayments, or coinsurance, from the date of Suspension of Coverage through the date of reinstatement. The QHP issuer shall reimburse the APTC enrollee for any expenses incurred pursuant to this section within 30 days of receipt of the claim for the health care service.~~

~~(f) If the APTC enrollee fails to pay outstanding premiums before the exhaustion of the federal grace period, the QHP issuer may cancel or not renew the APTC enrollee's coverage consistent with 45 CFR part 155.430 and section 1365 of the Act.~~

~~(g) Review and Enforcement~~

~~The failure of a plan to comply with the requirements of section 1365 of the Act and this regulation may constitute a basis for disciplinary action against the plan. The Director shall have the civil, criminal, and administrative remedies available under the Act, including Health and Safety Code section 1394.~~

~~NOTE: AUTHORITY CITED: SECTION 1344, HEALTH AND SAFETY CODE. REFERENCE: SECTION 1365, HEALTH AND SAFETY CODE.~~

§ 1300.65. Cancellations, Rescissions, and Nonrenewals of an Enrollment or Subscription.

(a) Definitions

The terms used in Health and Safety Code sections 1365 and 1389.21, as well as the terms used in this Article, are defined as follows:

(1) "APTC enrollee" means an individual, an enrollee or a subscriber in the individual market who is currently a recipient of advance payments of the premium tax credit ("APTC") pursuant to the federal Patient Protection and Affordable Care Act ("PPACA") at section 1401 (26 U.S.C. § 36B).

(2) "Billed for the charge" means the enrollee, subscriber, or group contract holder was sent a bill that provides, at a minimum, an accurate itemization of the premium amount(s) due, the due date(s), and the period(s) of time covered by the premium(s). The bill shall also include the following statement in at least 12-point font:

Your health plan is billing you for the cost of your health coverage. You must pay all amounts listed in this bill by the due date. If you do not pay this amount by the due date, your health coverage can be cancelled. You will receive a grace period before your plan can cancel your coverage for not paying the amount due. You can file a complaint with your plan and with the California Department of Managed Health Care if you think there is a mistake. Learn more about your health care rights and responsibilities in your plan Evidence of Coverage.

(3) "Cancelled," "not renewed" or "nonrenewal" means termination of coverage initiated by the plan during or at the conclusion of the contract term, but does not include the following:

(A) Voluntary termination at the request of the enrollee or subscriber.

(B) Termination for failure to satisfy any statutory or regulatory eligibility requirements under federal or state law.

(C) Exhaustion of any time-limited coverage provided by federal or state law, including, but not limited to, continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (section 4980B of Title 26 of the United States Code, sections 1161 et seq. of Title 29 of the United States Code, and section 300bb of Title 42 of the United States Code) or Cal-COBRA (Health and Safety Code sections 1366.20 through 1366.29).

(D) Prospective termination for failure to satisfy eligibility requirements under a group plan contract, as follows:

- (i) Time-based employment requirements, including, but not limited to, a reduction in work hours;
- (ii) Marital or registered domestic partner status;
- (iii) Attainment of limiting age by dependent child;
- (iv) Group participation requirements; or
- (v) Service-area requirements.

(4) "Contractholder" or "contract holder" means the enrollee, subscriber, group, association or employer with which the plan has contracted to provide health services.

(5) "Enrollee" means a person who is enrolled in a plan and who is a recipient of services from the plan, as that term is defined in Health and Safety Code section 1345(c).

(6) "Enrollment," "subscription," or "contract" means "plan contract," as that term is defined in Health and Safety Code section 1345(r).

(7) "Exchange" or "Covered California" means the California Health Benefit Exchange established in Title 22 (commencing with section 100500) of the Government Code.

(8) "Federal grace period" means the period of three consecutive months a QHP Issuer must provide to an APTC enrollee, before terminating the APTC enrollee's health care coverage for nonpayment of premiums.

(9) "Grace period" means the period of at least 30 consecutive days beginning the day the Notice of Start of Grace Period is dated.

(10) "Grievance" means a written or oral expression of dissatisfaction to the plan or the Director regarding the plan and/or provider, including a written or oral expression of dissatisfaction by an enrollee, subscriber, or group contract holder who believes their plan contract, enrollment or subscription has been or will be improperly cancelled, rescinded or not renewed. The right to request a review by filing a complaint authorized under Health and Safety Code section 1365(b) shall be handled as an expedited grievance pursuant to the requirements of Health and Safety Code sections 1368 and 1368.01, and California Code of Regulations, title 28, sections 1300.68 and 1300.68.01.

(11) "Group contract holder" means a group, association, or employer that contracts with a plan to provide health care services to members or employees.

(12) "Individual" means enrollee or subscriber as defined in Health and Safety Code section 1345(c) and (p), respectively.

(13) "Non-Suspension QHP Issuer" means a health care service plan that does not pend claims for services given to the APTC enrollee in the second and third months of the federal grace period. A Non-Suspension QHP Issuer shall provide coverage to the APTC enrollee as required by the plan contract during the 3-month federal grace period.

(14) "Nonpayment of Premiums" means failure of the enrollee, subscriber, or group contract holder to pay any premium, or portion of premium, by the due date after having been billed for the charge.

(15) "Notice of Cancellation, Rescission or Nonrenewal" means notice sent by the plan to the enrollee, subscriber, or group contract holder that the plan contract will be cancelled, rescinded or not renewed for any reason other than nonpayment of premiums as permitted under California Code of Regulations, title 28, sections 1300.65.1 or 1300.89.21, or Health and Safety Code sections 1365 or 1389.21.

(16) "Notice of End of Coverage" means the notice sent to the enrollee, subscriber, or group contract holder notifying the recipient that the enrollee's coverage has been cancelled.

(17) "Notice of Start of Federal Grace Period" means notice sent by the plan to the enrollee or subscriber that the plan contract will be terminated unless the premium amount due is received by the plan no later than the last day of the Federal Grace Period.

(18) "Notice of Start of Grace Period" means the notice sent by the plan to the enrollee, subscriber, or group contract holder that the plan contract will be terminated unless the premium amount due is received by the plan no later than the last day of the Grace Period.

(19) "Outstanding premium" means the total premium amounts that have been billed to the enrollee, subscriber or group contract holder and are past due.

(20) "Plan" means a "health care service plan" or "specialized health care service plan," as those terms are defined in Health and Safety Code section 1345(f).

(21) "Premium payment threshold policy" means a plan's policy to consider an enrollee, subscriber, or group contract holder to have paid all amounts due if the enrollee, subscriber, or group contract holder pays an amount sufficient to maintain a percentage of total premium owed equal to or greater than a level prescribed by the plan, provided that the level is reasonable and that the level and policy are applied in a uniform manner to all enrollees, subscribers, contract holders, and group contract holders.

(22) "QHP Issuer" means, for the purposes of this Article, a plan licensed under the provisions of the Act and certified by the Exchange to market individual and/or small group products on the Exchange. Any of the requirements contained in California Code of Regulations, title 28, sections 1300.65, 1300.65.1, 1300.65.2, and 1300.65.3 that are delegated by a QHP Issuer to a delegated group shall also apply to that delegated group.

(23) "Qualified Health Plan" or "QHP" means a plan contract certified to be offered through the Exchange.

(24) "Rescission" or "rescind" means retroactive cancellation of coverage as defined in California Code of Regulations, title 28, section 1300.89.21.

(25) "Small employer" has the same meaning as defined in Health and Safety Code sections 1357(l), 1357.500(k) and 1357.600(k).

(26) "Suspension QHP Issuer" means a health care service plan that pends claims for services rendered to the enrollee in the second and third months of the federal grace period, pursuant to Title 45 of the Code of Federal Regulations, section 156.270.

(b) Grievance

(1) An enrollee, subscriber, or group contract holder who believes a plan contract, enrollment or subscription has been or will be improperly canceled, rescinded, or not renewed shall have at least 180 days from the date of the notice that the enrollee, subscriber, or group contract holder alleges to be improper to submit a grievance to the plan. An enrollee, subscriber, or group contract holder may also submit a grievance to the Director. An enrollee, subscriber, or group contract holder's right to submit a grievance is pursuant to Health and Safety Code sections 1365, 1368, and 1368.01.

(2) A grievance of an enrollee, subscriber, or group contract holder to the plan shall be processed pursuant to California Code of Regulations, title 28, section 1300.68.01. If the enrollee, subscriber, or group contract holder submits a grievance to the plan regarding a cancellation, rescission, or nonrenewal, the plan shall provide the Department and the enrollee, subscriber, or group contract holder with a disposition or pending status on the grievance within three (3) calendar days of receipt of the grievance by the plan pursuant to Health and Safety Code section 1368 and California Code of Regulations, title 28, section 1300.68.01(a)(2). Health and Safety Code section 1368(a)(4)(B)(i) and California Code of Regulations, title 28, section 1300.68(d)(8) shall not exempt a plan from complying with any requirement for written acknowledgement and response to an enrollee's grievance, as that term is defined in this Article.

(3) An enrollee, subscriber, or group contract holder's grievance to the Director shall be processed to determine if a proper complaint exists pursuant to Health and Safety Code section 1365(b)(2), including a determination if the grievance is timely, complete, and within the Director's jurisdiction. If a proper complaint does exist, the Director shall notify the enrollee, subscriber, or group contract holder, and the plan that the grievance has been accepted within 48 hours of the determination that the grievance is a proper complaint.

(4) Within 1 business day of receipt of the Director's notice of acceptance of proper complaint, the plan shall provide the Director with a copy of all information the plan used to make its determination and all other relevant information necessary for the Director's review pursuant to California Code of Regulations, title 28, section 1300.68(g)(1) through (g)(6).

(5) If an enrollee, subscriber, or group contract holder submits a grievance before the effective date of a cancellation, rescission, or nonrenewal, the plan shall continue to provide coverage as specified in California Code of Regulations, title 28, section 1300.65(c).

(6) Within 30 calendar days of the receipt of a grievance, or longer if the Director determines in his or her discretion that additional time is necessary to review the cancellation, rescission, or nonrenewal, the Director shall, pursuant to Health and Safety Code section 1368(b)(5), send written notice of the final determination and reasons for the determination to the enrollee, subscriber, or group contract holder, and to the plan.

(7) If the Director determines the cancellation, rescission, or nonrenewal fails to comply with all legal requirements, including, but not limited to, all notice and timing requirements in this Article, the Director shall order reinstatement, in accordance with California Code of Regulations, title 28, section 1300.65(d), or direct the plan not to cancel coverage.

(8) If the Director finds the cancellation, rescission, or nonrenewal was proper, but the effective date was in violation of the requirements of this Article, the Director may exercise his or her discretion and adjust the effective date of the cancellation, rescission, or nonrenewal accordingly and notify the enrollee, subscriber, or group contract holder, as well as the plan of the adjusted cancellation date.

(c) Continuation of Coverage

(1) If the enrollee, subscriber, or group contract holder files a grievance before the effective date of a cancellation, rescission, or nonrenewal, for reasons other than nonpayment of premiums, the plan shall continue to provide coverage to the enrollee, subscriber, or contract holder pursuant to the terms of the plan contract while the grievance is pending with the plan and/or Director.

(2) During the period of continued coverage, the enrollee, subscriber, or group contract holder remains responsible for paying premiums and any copayments, coinsurance, or deductible obligations as required under the plan contract.

(3) If the Director determines the cancellation or nonrenewal for nonpayment of premiums is consistent with existing law, and if the enrollee or subscriber is not entitled to the federal grace period, the cancellation date shall comply with California Code of Regulations, title 28, section 1300.65.2(a)(5). Under the federal grace period, if the Director determines the cancellation or nonrenewal is consistent with existing law, the cancellation date shall comply with California Code of Regulations, title 28, section 1300.65.3(a)(5)(A). The enrollee, subscriber, or group contract holder shall be responsible only for the required premium and cost sharing obligations incurred during the continued coverage period.

(4) If the Director determines the rescission is consistent with existing law, the plan shall return all premiums paid by the enrollee, subscriber, or group contract holder. The enrollee, subscriber, or group contract holder is responsible for the cost of all medical services received after the effective date of the rescission as defined in California Code of Regulations, title 28, section 1300.89.21(a).

(d) Reinstatement of Coverage

(1) If the Director determines the cancellation, rescission, or nonrenewal, including a cancellation for nonpayment of premium, does not comply with existing law, and the enrollee, subscriber, or group contract holder submitted the grievance after the plan contract was cancelled, rescinded, or not renewed, the Director shall order the plan to reinstate the enrollee, subscriber, or contract holder, retroactive to the effective date of cancellation, rescission, or nonrenewal.

(2) Within 15 days after receipt of the order for reinstatement, the plan shall either request an administrative hearing from the Director or reinstate the enrollee, subscriber, or contract holder.

(3) If the Director orders reinstatement, the plan shall be liable for the expenses incurred by the enrollee, subscriber, or group contract holder for covered health care services, less any applicable deductibles, copayments, or coinsurance pursuant to the enrollee, subscriber, or group contract holder's Evidence of Coverage, from the effective date of cancellation, rescission, or nonrenewal through the date of reinstatement. The plan shall reimburse the enrollee, subscriber, or group contract holder for any medical expenses incurred by the enrollee, subscriber, or contract holder pursuant to this subdivision within 30 days of receipt of the complete claim, as defined in California Code of Regulations, title 28, section 1300.71(a)(2).

(4) The enrollee, subscriber, or group contract holder shall be responsible for any and all premium payments accrued from the effective date of cancellation, rescission, or nonrenewal. An enrollee, subscriber, or group contract holder must pay all outstanding premiums before reinstatement.

(e) Applicability

The provisions in California Code of Regulations, title 28, sections 1300.65, 1300.65.1, 1300.65.2, 1300.65.3, 1300.65.4, and 1300.65.5 shall not apply to a plan contract offered in the Medi-Cal program (Chapters 7 (commencing with section 14000) and 8 (commencing with section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code).

(f) Format and Transmission Requirements Under this Article

(1) Except for the notice required under Health and Safety Code section 1389.21, notices shall be sent by any reasonable method of transmission, including paper, electronic, or another method of transmission specifically agreed to by the enrollee, subscriber, or group contract holder.

(2) The enrollee, subscriber, or group contract holder may agree to the electronic transmission of all notices under this Article, but shall not be required to opt-in to receive paper notices. For any method of transmission other than paper, the plan shall maintain a copy of the specific agreement for the method of transmission.

(3) For any method of transmission other than paper, the plan shall have a tracking system to demonstrate notices were sent in compliance with the agreement between the plan and enrollee, subscriber, or group contract holder, and applicable law.

(4) Except as otherwise required under this Article, notices shall appear in at least 12-point font.

Note: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1365, 1368, 1368.01 and 1389.21, Health and Safety Code.

§ 1300.65.1. Cancellations, Rescissions, or Nonrenewals for Reasons Other than Nonpayment of Premiums.

(a) General Requirements

(1) Applicability. This section shall apply to all cancellations for reasons other than for nonpayment of premiums.

(2) The plan shall send a Notice of Cancellation, Rescission, or Nonrenewal for all cancellations other than cancellations due to the nonpayment of premium. At a minimum, this Notice shall contain the information set forth in California Code of Regulations, title 28, section 1300.65.1(b)(1). The Notice of Cancellation, Rescission, or Nonrenewal shall be sent to the enrollee, subscriber, or group contract holder:

(A) At least 30 days before the cancellation, rescission, or nonrenewal for fraud or intentional misrepresentation of material fact pursuant to Health and Safety Code sections 1365(a)(2) or 1389.21, subject to limitations imposed by Health and Safety Code section 1389.21.

(B) At least 30 days before the cancellation, rescission, or nonrenewal for a cancellation or nonrenewal pursuant to Health and Safety Code sections 1365(a)(3), (4) or (7).

(C) At least 180 days before the discontinuation or termination of a contract if the cancellation or nonrenewal is due to the plan ceasing to provide or arrange for the provision of health benefits for new plan contracts in the individual or group market in this state pursuant to Health and Safety Code section 1365(a)(5). A notice sent pursuant to this subdivision shall also be sent concurrently to the Director.

(D) At least 90 days before the withdrawal of a health benefit plan from the market pursuant to Health and Safety Code section 1365(a)(6). A notice sent pursuant to this subdivision shall also be sent concurrently to the Director.

(3) The plan shall send a Notice of Cancellation, Rescission, or Nonrenewal to each subscriber in a group contract unless:

(A) The plan contract requires the group contract holder to promptly send any such Notice to each subscriber; and

(B) The plan sends the Notice to the group contract holder designated in the plan contract.

(4) The plan shall send a Notice of End of Coverage for all cancellations. This Notice shall be sent to the enrollee, subscriber, or group contract holder after the date coverage ended, and no later than five (5) calendar days after the date coverage ended. At a minimum, this Notice shall contain the information set forth in California Code of Regulations, title 28, section 1300.65.1(b)(2).

(5) When required pursuant to Health and Safety Code section 1373.96(m), notice as to the availability of the right to request completion of covered services shall be part of, accompany, or be sent simultaneously with both the Notice of Cancellation, Rescission, or Nonrenewal and the Notice of End of Coverage.

(b) Elements of Notices:

(1) Notice of Cancellation, Rescission, or Nonrenewal

The Notice of Cancellation, Rescission, or Nonrenewal shall comply with all applicable federal and state requirements, and shall include all of the following:

(A) The title "Notice of Cancellation, Rescission, or Nonrenewal" displayed in 20-point bolded font at the top of the first page of the notice;

(B) The name and contact information for the enrollee, subscriber, or group contract holder;

(C) For all contracts issued in the individual market, the names of all enrollees affected by the notice;

(D) The date of the notice;

(E) Reason for the cancellation, rescission, or nonrenewal;

(F) Effective date of the cancellation, rescission, or nonrenewal, expressed as a month, day and year;

(G) The notice of grievance rights in accordance with Health and Safety Code section 1365(b) as set forth in California Code of Regulations, title 28, section 1300.65.5; and

(H) Any notice required under Health and Safety Code section 1366.50.

(2) Notice of End of Coverage

The Notice of End of Coverage shall comply with all applicable federal and state requirements, and shall include all of the following:

(A) The title "Notice of End of Coverage" displayed in 20-point bolded font at the top of the first page of the notice;

(B) The name and contact information for the enrollee, subscriber, or group contract holder;

(C) For all contracts issued in the individual market, the names of all enrollees affected by the notice;

(D) The date of the notice;

(E) The effective date of cancellation, rescission, or nonrenewal, expressed as a month, day and year;

(F) The reason for cancellation, rescission, or nonrenewal;

(G) The notice of grievance rights in accordance with Health and Safety Code section 1365(b) as set forth in California Code of Regulations, title 28, section 1300.65.5;

- (H) Any notice required under Health and Safety Code section 1366.50; and
- (I) The following statement: "To learn about new coverage or whether your coverage can be reinstated, contact [health plan] at [contact information]."

Note: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1365, 1366.50, 1373.96 and 1389.21, Health and Safety Code.

§ 1300.65.2. Cancellations or Nonrenewals for Nonpayment of Premiums.

(a) General Requirements

(1) Applicability. This section shall apply to all cancellations and nonrenewals for nonpayment of premiums pursuant to Health and Safety Code section 1365(a)(1)(A), unless an enrollee, subscriber, or group contract holder is entitled to a longer grace period pursuant to state or federal law.

(2) Grace Period

(A) The grace period may not begin sooner than the day after the last date of paid coverage. Grace period is defined in California Code of Regulations, title 28, section 1300.65(a)(9).

(B) A plan shall provide coverage pursuant to the terms of the contract during the entire grace period. The term "Grace Period" does not include the "Federal Grace Period," as defined in California Code of Regulations, title 28, section 1300.65(a)(8), which applies to individuals receiving APTC pursuant to the PPACA, section 1401 (26 U.S.C. § 36B).

(3) Notices

(A) Upon determining that an enrollee, subscriber, or group contract holder has failed to make a premium payment by the due date, the plan shall send a Notice of Start of Grace Period to the enrollee, subscriber, or group contract holder, notifying the recipient that a payment delinquency has triggered a grace period starting from the day the Notice of Start of Grace Period is dated. This Notice shall, at minimum, contain the information set forth in California Code of Regulations, title 28, section 1300.65.2(b)(1).

(B) The plan shall send a Notice of Start of Grace Period to each subscriber in a group contract unless:
(i) The plan contract requires the group contract holder to promptly send any such Notice to each subscriber; and
(ii) The plan sends the Notice to the group contract holder designated in the plan contract.

(C) A plan shall not delegate the responsibility for sending the Notice of Start of Grace Period to a group contract holder for each subscriber in the group unless the plan has complied with California Code of Regulations, title 28, section 1300.65.2(a)(3)(B).

(D) In the case where a plan has delegated the responsibility for sending the Notice of Start of Grace Period to a group contract holder, the Notice of Start of Grace Period to the group contract holder triggers the 30-day grace period. Any subsequent notice to the subscribers in the group does not restart the 30-day grace period.

(E) For the purposes of this section, all plans shall notify an enrollee, subscriber, or group contract holder when the plan has cancelled, rescinded, or not renewed health coverage in one of the following two ways:

- (i) Send a written notice of termination to the enrollee, subscriber, or group contract holder, when required pursuant to California Code of Regulations, title 10, section 6506(e)(1). This notice shall include the notice of grievance rights set forth in California Code of Regulations, title 28, section 1300.65.5, and any notice required under Health and Safety Code section 1366.50; or
- (ii) Send the Notice of End of Coverage. This Notice shall be sent after the date coverage ends, and no later than five calendar days after the date coverage ended. At a minimum, this Notice shall contain the information set forth in California Code of Regulations, title 28, section 1300.65.2(b)(2).

(4) Notwithstanding California Code of Regulations, title 28, section 1300.65(a)(14), a plan may implement a premium payment threshold policy, as defined in California Code of Regulations, title 28, section 1300.65(a)(21).

(5) In the event the plan, after compliance with all timing and notice requirements of this section, fails to receive all outstanding premium amounts from the enrollee, subscriber, or group contract holder on or before the last day of the grace period, as specified in the Notice of Start of Grace Period, coverage may be cancelled prospectively only after the expiration of the entire grace period.

(6) The plan shall continue the enrollee, subscriber, and/or group contract holder's coverage uninterrupted pursuant to the plan contract upon payment of all outstanding premium amounts at any time before the expiration of the grace period.

(7) The enrollee, subscriber, or group contract holder is financially responsible for any and all premiums and any copayments, coinsurance, or deductible amounts obligated under the plan contract, including those incurred for services received during the grace period.

(b) Elements of Notices

(1) Notice of Start of Grace Period

The Notice of Start of Grace Period shall comply with all applicable federal and state requirements, and shall include all of the following:

- (A) The title "Notice of Start of Grace Period" displayed in 20-point bolded font at the top of the first page of the notice;
- (B) The name and contact information for the enrollee, subscriber, or group contract holder;
- (C) For all contracts issued in the individual market, the names of all enrollees affected by the notice;
- (D) The date of the notice, expressed as a month, day and year;
- (E) A statement indicating the specific date the grace period begins;
- (F) The dollar amount past due. This amount shall indicate the amounts owed by month if more than one month is past due;
- (G) The date of the last day of paid coverage, expressed as a month, day and year;
- (H) The name of the plan;
- (I) An explanation of the grace period and the specific date the grace period expires, expressed as a month, day and year;
- (J) The telephone number for the plan's customer service; and

(K) A statement explaining the consequence of losing coverage, including, financial responsibility for the payment of claims incurred and the obligations of the subscriber.

(2) Notice of End of Coverage

The Notice of End of Coverage shall comply with all applicable federal and state requirements, and shall include all of the following:

(A) The title "Notice of End of Coverage" displayed in 20-point bolded font at the top of the first page of the notice;

(B) The name and contact information for the enrollee, subscriber, or group contract holder;

(C) For all contracts issued in the individual market, the names of all enrollees affected by the notice;

(D) The date of the notice;

(E) The effective date of cancellation, expressed as a month, day and year;

(F) The reason for cancellation;

(G) The notice of grievance rights in accordance with Health and Safety Code section 1365(b) and California Code of Regulations, title 28, section 1300.65.5;

(H) Any notice required under Health and Safety Code section 1366.50; and

(I) The following statement: "To learn about new coverage or whether your coverage can be reinstated, contact [health plan] at [contact information]."

Note: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1365 and 1366.50, Health and Safety Code.

§ 1300.65.3. Cancellations or Nonrenewals for Nonpayment of Premiums: APTC Enrollee.

(a) General Requirements

(1) Applicability. This section shall apply to all cancellations and nonrenewals for nonpayment of premiums for an enrollee who is receiving the APTC through the PPACA, section 1401 (26 U.S.C. § 36B), pursuant to Health and Safety Code section 1365(a)(1)(A).

(2) Federal Grace Period

(A) To qualify for the federal grace period, as defined in California Code of Regulations, title 28, section 1300.65(a)(8), an APTC enrollee shall have paid at least one full month's premium before the nonpayment of premiums.

(B) The federal grace period begins the first day after the last day of paid coverage and lasts for three full consecutive months.

(C) Notwithstanding California Code of Regulations, title 28, section 1300.65(a)(14), a QHP Issuer may implement a premium payment threshold policy, as defined in California Code of Regulations, title 28, section 1300.65(a)(21).

(D) Upon determining that an APTC enrollee has failed to make a premium payment by the due date, the QHP Issuer shall send a "Notice of Start of Federal Grace Period" to the APTC enrollee, notifying the recipient that a payment delinquency has triggered a 3-month federal grace period starting from the first day after the last day of paid coverage.

(E) The Notice of Start of Federal Grace Period sent to the APTC enrollee shall not be mailed or dated on or before the premium due date for which the APTC enrollee is receiving the Notice. The Notice of Start of Federal Grace Period must be sent on or before the fifth (5th) business day after the start of the federal grace period. However, in the event a QHP Issuer learns of a payment delinquency between the last day of paid coverage and the fifteenth (15th) day of the first month of the federal grace period, due to the discovery of insufficient funds, a rejected credit card payment, or a similar event, the QHP Issuer shall send the Notice of Start of Federal Grace Period within five (5) calendar days of learning of the payment delinquency. A Suspension QHP Issuer that fails to send the Notice of Start of Federal Grace Period by the applicable deadline(s) shall not suspend the APTC enrollee's coverage during the second and third months of the federal grace period.

(3) Suspension of Coverage

(A) Suspension of coverage during months two and three of the federal grace period is optional for the plan.

(B) A Non-Suspension QHP Issuer shall not take or threaten action that causes or suggests that the APTC enrollee's coverage may be suspended. A Non-Suspension QHP Issuer shall:

- (i) Provide its APTC enrollees with the 3-month federal grace period,
- (ii) Provide coverage to the APTC enrollee as required by the plan contract during the 3-month federal grace period,
- (iii) Pay all claims for covered health care services rendered during the 3-month federal grace period, notwithstanding California Code of Regulations, title 28, section 1300.65.3(a)(5)(A), and
- (iv) Not hold an APTC enrollee financially responsible for the costs of claims for covered health care services rendered during the 3-month federal grace period, even if cancellation occurs for nonpayment of premium. An APTC enrollee remains responsible for payment of outstanding premiums and any applicable deductibles, copayments, and coinsurance, pursuant to the APTC enrollee's Evidence of Coverage, accrued during the 3-month federal grace period, even if cancellation occurs for nonpayment of premium.

(C) To suspend an enrollee during months two and three of the federal grace period, a Suspension QHP Issuer shall:

- (i) Comply with any and all notice requirements to the enrollee related to suspension of coverage;
- (ii) Make any necessary system adjustments by day 1 of the second month of the federal grace period to the QHP Issuer's real time eligibility and verification system to accurately reflect the APTC enrollee's suspension of coverage; and
- (iii) Reinstate the APTC enrollee, retroactive to the last day of the first month, if the APTC enrollee pays all outstanding premium amounts before the end of the federal grace period.

(D) During the first month of the federal grace period, the Suspension QHP Issuer shall:

- (i) Provide coverage to the APTC enrollee as required by the plan contract; and
- (ii) If the APTC enrollee does not pay outstanding premium amounts by day 15 of the first month of the federal grace period, the Suspension QHP Issuer shall send a Notice of Suspension to the APTC enrollee, and shall send a separate Notice of Suspension to providers. Both notices shall be sent no earlier than day 16 of the first month of the federal grace period but no later than the end of the first month of the federal grace period.

(E) During months two and three of the federal grace period, the Suspension QHP Issuer shall:

(i) Suspend or pend claims for services rendered to the APTC enrollee; and

(ii) Make any necessary system adjustments by day 1 of the second month of the federal grace period to the Suspension QHP Issuer's real time eligibility and verification system to accurately reflect the APTC enrollee's suspension of coverage. For the purposes of this subdivision, the QHP Issuer shall use only the terms "coverage pending," "coverage suspended," or "inactive pending investigation" so as to clearly communicate the status of the APTC enrollee.

(F) During the suspension of coverage, the APTC enrollee:

(i) Remains responsible for making all delinquent and ongoing premium payments; and

(ii) May submit a grievance pursuant to Health and Safety Code section 1365(b).

(G) The Notice of Suspension shall be given to the APTC enrollee's assigned group, assigned network provider, any provider with an outstanding prior authorization to provide services to the APTC enrollee, and any network provider that submitted claims for the APTC enrollee in the two months prior to the start of the APTC enrollee's federal grace period.

(i) This notice requirement is in addition to the provider's ability to verify APTC enrollee eligibility for coverage with the QHP Issuer.

(ii) This notice requirement does not replace a provider's responsibility to verify eligibility for coverage of an APTC enrollee with the QHP Issuer before providing health care services.

(iii) In the event the Suspension QHP Issuer does not provide the notice to the APTC enrollee's providers or does not update its real time eligibility and verification system by day 1 of the second month of the federal grace period, and providers provide health care services to the APTC enrollee, the Suspension QHP Issuer shall be responsible for paying the claim costs of the APTC enrollee that would have been covered under the plan contract notwithstanding the Suspension of Coverage.

(4) Reinstatement of Coverage

(A) In the event that an APTC enrollee does not pay all outstanding premium amounts before the next premium due date, the QHP Issuer shall bill the APTC enrollee in the same form and manner of billing as if the APTC enrollee were not in the federal grace period, and include in the billing statement the total premium amounts owing at the end of the billing cycle.

(B) Upon payment of all outstanding premium amounts at any time before the expiration of the federal grace period, the QHP Issuer shall reinstate the APTC enrollee's coverage pursuant to the plan contract and immediately update its real time eligibility and verification system to reflect an "active" status.

(C) If an APTC enrollee with coverage through a Suspension QHP Issuer pays all outstanding premium amounts before the end of the federal grace period, the Suspension QHP Issuer shall be liable for the claims covered under the APTC enrollee's Evidence of Coverage less any applicable deductibles, copayments, or coinsurance, from the date of suspension of coverage through the date of reinstatement. The Suspension QHP Issuer shall reimburse the APTC enrollee for any medical expenses incurred pursuant to this subdivision within 30 days of receipt of the complete claim, as defined in California Code of Regulations, title 28, section 1300.71(a)(2).

(5) Cancellation or Nonrenewal Following Federal Grace Period

If the APTC enrollee fails to pay outstanding premium amounts on or before the last day of the federal grace period, the QHP Issuer shall cancel or not renew the APTC enrollee's health care coverage.

(A) The effective date of cancellation for an APTC enrollee canceled or not renewed by a Suspension QHP Issuer or by a Non-Suspension QHP Issuer shall be the day after the last day of the first month of the 3-month federal grace period pursuant to 45 Code of Federal Regulations part 155.430(d)(4).

(B) For the purposes of this section, all plans shall notify an enrollee, subscriber, or group contract holder when the plan has cancelled, rescinded, or not renewed health coverage in one of the following two ways:

(i) Send a written notice of termination to the enrollee, subscriber, or group contract holder, when required pursuant to California Code of Regulations, title 10, section 6506(e)(1). This notice shall include the notice of grievance rights set forth in California Code of Regulations, title 28, section 1300.65.5, and any notice required under Health and Safety Code section 1366.50, or

(ii) Send the Notice of End of Coverage. This Notice shall be sent after the date coverage ends, and no later than five calendar days after the date coverage ended. At a minimum, this Notice shall contain the information set forth in California Code of Regulations, title 28, section 1300.65.3(b)(4).

(b) Notice Requirements

(1) Notice of Start of Federal Grace Period to APTC Enrollee

The Notice of Start of Federal Grace Period to the APTC Enrollee shall comply with all applicable federal and state requirements, and shall include all of the following:

(A) The title "Notice of Start of Federal Grace Period" displayed in 20-point bolded font at the top of the notice;

(B) The name and contact information for the APTC enrollee;

(C) The names of all APTC enrollees affected by the notice;

(D) The date of the notice;

(E) The date of the first day of the federal grace period, expressed as a month, day and year;

(F) The dollar amount past due. This amount shall indicate the amounts owed by month if more than one month is past due;

(G) The date of the last day of paid coverage, expressed as a month, day and year;

(H) The name of the QHP Issuer;

(I) An explanation of the three-month federal grace period and the date the federal grace period expires;

(J) The telephone number for the QHP Issuer's customer service; and

(K) A statement explaining the consequence of losing coverage, including financial responsibility for the payment of claims incurred and the obligations of the subscriber.

(2) Notice of Suspension to APTC Enrollee

The Notice of Suspension to the APTC enrollee shall comply with all applicable federal and state requirements, and shall include all of the following:

(A) The title "Notice of Suspension" displayed in 20-point bolded font at the top of the first page of the notice;

(B) The name and contact information for the APTC enrollee;

- (C) The names of all APTC enrollees affected by the notice;
- (D) The date of the notice;
- (E) A statement indicating the start date of the federal grace period;
- (F) The dollar amount past due. This amount shall indicate the amounts owed by month if more than one month is past due;
- (G) Date of the last day of paid coverage, expressed as a month, day and year;
- (H)The name of the QHP Issuer;
- (I) An explanation of the three-month federal grace period and the date the federal grace period expires;
- (J) An explanation of the suspension of coverage during the second and third months of the federal grace period and the start and end dates of the suspension of coverage;
- (K) An explanation that the APTC enrollee must pay the total outstanding premium in order to exit the federal grace period and prevent coverage from ending;
- (L) The telephone number for the QHP Issuer's customer service;
- (M) Consequence of losing coverage, including financial responsibility for the payment of claims incurred and the obligations of the APTC enrollee; and
- (N) The notice of grievance rights in accordance with Health and Safety Code section 1365(b) and California Code of Regulations, title 28, section 1300.65.5.

(3) Notice of Suspension to APTC Enrollee's Provider(s)

The Notice of Suspension to the APTC Enrollee's Provider(s) shall comply with all applicable federal and state requirements, and shall include all of the following:

- (A) The title "Notice of Suspension to APTC Enrollee's Provider" displayed in 20-point bolded font at the top of the notice;
- (B) The names of all APTC enrollees affected by the notice;
- (C) The date of the notice;
- (D) The name of the Suspension QHP Issuer for the APTC enrollee;
- (E) An explanation of the suspension of coverage during the second and third months of the federal grace period, and the start and end dates of the suspension of coverage; and
- (F) The Suspension QHP Issuer's customer service telephone number for providers.

(4) Notice of End of Coverage

The Notice of End of Coverage shall comply with all applicable federal and state requirements, and shall include all of the following:

- (A) The title "Notice of End of Coverage" displayed in 20-point bolded font at the top of the notice;
- (B) The name and contact information for the APTC enrollee;
- (C) The names of all APTC enrollees affected by the notice;
- (D) The date of the notice;
- (E) The end of coverage effective date, expressed as a month, day and year;
- (F) The reason for end of coverage;
- (G) The notice of grievance rights in accordance with Health and Safety Code section 1365(b) and California Code of Regulations, title 28, section 1300.65.5;
- (H) Any notice required under Health and Safety Code section 1366.50; and
- (I) The following statement: "To learn about new coverage or whether your coverage can be reinstated, contact [health plan] at [contact information]."

Note: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1365, Health and Safety Code; and Code of Federal Regulations, title 45, part 156.270.

§ 1300.65.4. Grievance Form for Cancellations, Rescissions, and Nonrenewals of an Enrollment or Subscription.

(a) Grievances to the Director pursuant to Health and Safety Code section 1365(b) may be made electronically, verbally, or in writing signed by the enrollee, subscriber, or group contract holder (or their legal representative).

(b) An enrollee, subscriber, or group contract holder is not required to use a specific form to submit a written grievance to the Director pursuant to Health and Safety Code section 1365(b)(1). An enrollee, subscriber, or group contract holder may submit a written grievance using any form that, at a minimum, contains the information enumerated in California Code of Regulations, title 28, section 1300.65.4(d), and addressed to:

Department of Managed Health Care
Help Center
980 9th Street, Suite 500
Sacramento, CA 95814

(c) The plan shall make readily available to its members a form that, at a minimum, contains the information enumerated in California Code of Regulations, title 28, section 1300.65.4(d).

(d) An enrollee, subscriber, or group contract holder may submit a written grievance using a form that, at a minimum, contains fields for, or notice of, the following information:

- (1) Full name of enrollee, subscriber, or group contract holder filing the grievance;
- (2) Name and identification number(s) of all enrollees affected;
- (3) Name of parent or guardian, if filing for minor child enrollee;
- (4) Date of birth;
- (5) Gender, as follows:

Gender: Male Female Other _____

- (6) Mailing address;
- (7) Daytime phone number;
- (8) Evening phone number;
- (9) Email address;
- (10) Health plan name;
- (11) Health plan membership number;
- (12) Medical group name, if applicable;
- (13) Employer, if applicable;
- (14) Medi-Cal identification number, if applicable;
- (15) Medicare or Medicare Advantage identification number, if applicable;
- (16) Date enrollee received notice that coverage was or will end;
- (17) Date enrollee filed a grievance with an entity other than the Department, if applicable;

- (18) Copies of plan notice(s) and correspondence(s) received, if any;
- (19) Copies of enrollee correspondence(s) sent, if any;
- (20) Copies of proof of payment for the last paid coverage period;
- (21) A Medical Release, if necessary, as follows:

MEDICAL RELEASE

I request that the Department of Managed Health Care (DMHC) make a decision about my problem with my plan. I request that the DMHC review my Cancellation of Health Coverage Grievance Form to determine if my grievance qualifies for the DMHC's Consumer Complaint process. I allow my providers, past and present, and my plan to release my medical records and information to review this issue. These records may include medical, mental health, substance abuse, HIV, diagnostic imaging reports, and other records related to my grievance. These records may also include non-medical records and any other information related to my grievance. I allow the DMHC to review these records and information and send them to my plan. My permission will end one year from the date below, except as allowed by law. For example, the law allows the DMHC to continue to use my information internally. I can end my permission sooner if I wish. All the information that I have provided on this sheet is true.

Enrollee, Legal Guardian, or Parent Signature: _____

Date: _____

Please see the instruction sheet for mailing or faxing information.

- (22) An Authorized Assistant Form, if necessary, as follows:

AUTHORIZED ASSISTANT FORM

If you want to give another person permission to assist you with your grievance, complete Parts A and B below.

If you are a parent or legal guardian submitting this grievance for a child under the age of 18, you do not need to complete this form.

If you are filing this grievance for an enrollee who cannot complete this form because the enrollee is either incompetent or incapacitated, and you have legal authority to act for this enrollee, please complete Part B only. Also attach a copy of the power of attorney for health care decisions or other documents that say you can make decisions for the enrollee.

PART A: ENROLLEE

I allow the person named below in Part B to assist me in my grievance filed with the DMHC. I allow the DMHC staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my grievance will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing.

Enrollee Signature: _____ Date: _____

PART B: PERSON ASSISTING ENROLLEE

Name of Person Assisting (print):

Signature of Person Assisting:

Street Address:

City: _____ State: _____ Zip: _____

Relationship to Enrollee:

Daytime Phone Number: _____ Evening Phone Number: _____

Email Address (if available):

My power of attorney for health care decisions or other legal document is attached: _____ (check if applicable)

(23) An Instruction Sheet, as follows:

GRIEVANCE/COMPLAINT FORM INSTRUCTION SHEET

If you have questions, call the Help Center at 1-888-466-2219 or TDD at 1-877-688-9891. This call is free.

How to File:

1. File online at www.HealthHelp.ca.gov. [This is the fastest way.]

OR

Fill out and sign the Cancellation of Health Care Coverage Grievance Form.

2. If you want someone to help you with your grievance, complete the Authorized Assistant Form.
3. Include documents requested on the Cancellation of Health Care Coverage Grievance Form, such as notices from your health plan, billing statements, and proof of payment.
4. If you are not submitting online, please mail or fax your form and any supporting documents to:

Department of Managed Health Care

Help Center

980 9th Street, Suite 500

Sacramento, CA 95814-2725

FAX: 916-255-5241

What Happens Next?

The Help Center will send you a letter telling you if your grievance has been accepted. If your grievance is accepted, a decision about your issue will be made within 30 days. You will be notified in writing of the decision.

(24) The Information Practices Act of 1977 Notice, as follows:

INFORMATION PRACTICES ACT OF 1977 NOTICE

The Information Practices Act of 1977 (California Civil Code section 1798.17) requires the following notice.

- California's Knox-Keene Act gives the DMHC the authority to regulate health plans and investigate the grievances of health plan members.
- The DMHC's Help Center uses your personal information to investigate your problem with your health plan.
- You provide the DMHC this information voluntarily. You do not have to provide this information. However, if you do not, the DMHC may not be able to investigate your grievance.
- The DMHC may share your personal information, as needed, with the plan and providers to investigate your grievance.
- The DMHC may also share your information with other government agencies as required or allowed by law.
- You have a right to see your personal information. To do this, contact the DMHC Records Request Coordinator, DMHC, Office of Legal Services, 980 9th Street Suite 500, Sacramento CA 95814-2725, or call 916-322-6727.

(25) Explanation of reason for filing the grievance; and

(26) Signature of enrollee.

Note: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1365, Health and Safety Code.

§ 1300.65.5. Notice of Right of Enrollee to Submit a Grievance.

The following language regarding the right of an enrollee, subscriber, or group contract holder to submit a grievance to the Department of Managed Health Care must appear in at least 12-point font when required by a section in this Article:

RIGHT TO SUBMIT GRIEVANCE REGARDING CANCELLATION, RESCISSION, OR NONRENEWAL OF YOUR PLAN ENROLLMENT, SUBSCRIPTION, OR CONTRACT.

If you believe your health care coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a grievance with the plan and/or the Department of Managed Health Care.

OPTION (1) - YOU MAY SUBMIT A GRIEVANCE TO YOUR PLAN.

* You may submit a grievance to [plan] by calling [plan phone number], online at [plan website], or by mailing your written grievance to [plan address].

* You may want to submit your grievance to [plan] first if you believe your cancellation, rescission, or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible.

* [Plan] will resolve your grievance or provide a pending status within three (3) calendar days. If you do not receive a response from the plan within three (3) calendar days, or if you are not satisfied in any way with the plan's response, you may submit a grievance to the Department of Managed Health Care as detailed under Option 2 below.

OPTION (2) - YOU MAY SUBMIT A GRIEVANCE DIRECTLY TO THE DEPARTMENT OF MANAGED HEALTH CARE.

* You may submit a grievance to the Department of Managed Health Care without first submitting it to the plan or after you have received the plan's decision on your grievance.

* You may submit a grievance to the Department of Managed Health Care online at:
WWW.HEALTHHELP.CA.GOV

* You may submit a grievance to the Department of Managed Health Care by mailing your written grievance to:

HELP CENTER
DEPARTMENT OF MANAGED HEALTH CARE
980 NINTH STREET, SUITE 500
SACRAMENTO, CALIFORNIA 95814-2725

* You may contact the Department of Managed Health Care for more information on filing a grievance at:

PHONE: 1-888-466-2219
TDD: 1-877-688-9891
FAX: 1-916-255-5241

Note: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1365 and 1368, Health and Safety Code.